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Issue Date: 09 April 2007

CASE NOS: 2006 DCW 1
2006 DCW 2

In the Matter of:

T. H.,
Claimant

v.

WMATA,
Employer,

and

THE SCHAFFERS COMPANIES,
Carrier.

Appearances:

Matthew Peffer, Esquire
For the Claimant

Donna J. Henderson, Esquire
For Respondent Employer and Carrier

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER AWARDING MEDICAL BENEFITS

Statement of the Case

This case involves a claim under the Longshore and Harbor Workers' Compensation Act ("the Act"), as amended, 33 U.S.C. § 901, *et seq.*, as extended by The District of Columbia Workmen's Compensation Act ("DCCA"), 36 D.C. Code § 501 *et. seq.,* and implementing

regulations at 20 CFR Part 702.[1] The law applies to claims in the District of Columbia for employment related injuries or deaths that occurred prior to July 26, 1982, the effective date of the District of Columbia Workers' Compensation Act, § 2-1501 *et seq*. Claimant is seeking medical benefits in the form of certain diagnostic studies to be paid for by the Washington Metropolitan Area Transit Authority (WMATA) ("Employer") and The Schaffer Companies of Pennsylvania ("Carrier") due to work-related injuries to Claimant's right shoulder which occurred on November 11, 1973.

The case is before this tribunal pursuant to two apparent orders of reference dated October 12, 2005, and November 1, 2005, respectively, from the Associate Director of the Office of Workers' Compensation Programs, Department of Employment Services of the Government of the District of Columbia. A second injury claim relating to May 20, 1974, is identified in the order of reference dated October 12, 2005, from the District of Columbia, but, the parties agree, and the record before this tribunal establishes, that the second injury claim has no material effect upon the resolution of the claim for benefits in the form of the diagnostic testing which Claimant has requested, and is effectively merged and held to be consolidated with the original claim identified in both orders of reference. (Tr. 10-11) Disability compensation is not in issue before this tribunal.

A stipulation dated March 18, 1976, specified that Claimant had reached maximum medical improvement, suffered a twelve and one-half percent permanent partial disability of the right arm and specified compensation therefor, and allowed an attorney's fee in an amount certain. The stipulation also confirmed that the Employer would continue to provide Claimant needed "medical attention in the future." (E-4) The accident and injury and related compensation are documented of record. (E-1,2,3,5) The relief requested is for payment by Respondent for diagnostic testing in the form of an EMG, nerve conduction study of the Claimant's right upper extremity, and an MRI of the cervical spine. (Tr. 7)

ISSUES

Is the Employer liable for the cost of performing certain diagnostic testing comprised of an MRI and an EMG upon the Claimant?[2]

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[1] The D.C. Act has been recodified as § 32-1501 et seq. All cited regulations refer to Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Employer's motion for summary decision dated February 13, 2006, was denied by this tribunal's order dated March 21, 2006 because material facts are in dispute. The evidentiary record was held open until March 31, 2006, but no further evidence was submitted and neither Claimant nor Employer filed a closing brief. To the extent pertinent, this tribunal has considered Employer's brief in support of its motion for summary decision. No formal hearing was held. By agreement of the parties, this decision was made on the documentary record.

[2] The parties agree that the issue is whether the requested tests are reasonable and necessary and causally related to the 1973 injury. (Tr. 49) The parties agree that the issue of the causal relationship of anything that might be revealed by the diagnostic studies to the 1973 injury is not before this tribunal at this time. Dr. Pereles contends that the tests are necessary for him to complete his current medical workup of the shoulder injury, since conservative treatment and surgery had not ended the shoulder pain. (Tr. 45-46) Employer contends that the neck is a noninjured body part, and that Claimant has received all appropriate treatment to his right shoulder as a result of the injury and orthopedic evaluations and surgeries. (Tr. 11-12) Employer also contends that Claimant's request for diagnostic

FINDINGS OF FACT

Claimant's Testimony

Claimant's testimony was consistent with the factual premises on which Dr. Pereles and Dr. Levitt based their assessments. At the time of the hearing Claimant was fifty-five years old, married, and employed as a grants clerk performing administrative and clerical functions for the National Institutes of Health (NIH). (Tr. 19) On November 11, 1973, he was employed by WMATA as a bus operator, when the bus struck a pothole in the street, which caused the steering wheel to jerk Claimant's arm, causing a sharp pain to his right shoulder and preventing further driving. (Tr. 20)[3] There was a recurrence in 1974, apparently in the nature of an aggravation which stopped him from working. (Tr. 34)

Claimant was treated by Dr. Collins, who performed surgery on the Claimant's right shoulder in 1975. Post operative care consisted of examinations by Dr. Collins, and physical therapy to improve the range of motion after the surgery had healed. There was initial improvement after the surgery, and Claimant returned to work as a bus operator three to six months later. But recurring pain in his right shoulder joint, between the collarbone and outer shoulder, including the shoulder itself, persisted after he left the employ of WMATA in 1976. (Tr. 21-23) On March 18, 1976, in a settlement, Claimant was awarded permanent partial disability compensation, having reached maximum medical improvement which did not identify the neck. (Tr. 57) Claimant testified that he had complained to Dr. Collins about neck pain, indicting that the pain went from his shoulder into his neck. (Tr. 36) His complaints are corroborated in Dr. Collins' pertinent medical records. (E-7) The symptoms persisted for the several years that Claimant was employed as a white collar worker in sales by a tire company and in project management and in sales by various telecommunications and other companies. (Tr. 23-25) Claimant testified that the claims he filed were for the injuries to the right shoulder, and that he complained of pain to the shoulder. (Tr. 34-35)

Claimant was having continuing difficulties with decreased motion of his right shoulder and pain while sleeping. Dr. Collins gave him a medication that made him sick. That caused Claimant to seek additional medical care from Dr. Pereles about 2003. (Tr. 25-26, 32) The pain has been in the trapezius area of his shoulder. (Tr. 35) Dr. Pereles prescribed pain medication, gave him cortisone injections, and ultimately, when Claimant was having acute pain between his shoulder and the collarbone and trouble moving his shoulder, did surgery in 2004. Dr. Levin did a presurgical evaluation at the request of Claimant's employer, and endorsed the procedure. (Tr. 26-27)

The surgery provided relief for about three months during the healing process and for six months thereafter, but the painful symptoms recurred, and Claimant had trouble raising his arm, carrying things, or putting weight on the shoulder. He advised Dr. Pereles, who recommended

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treatment related to the neck is made after twenty-five years of no treatment whatever, and that the proposed diagnostic search does not relate to the originally injured and treated body part. (Tr. 12)

[3] The technical documents tracing the reporting and processing of the injury are contained in Respondent's exhibits of record, but are immaterial to the resolution of the disputed issue before this tribunal. (E-1,2,3,5)

an MRI and nerve conduction study. Subsequently, Claimant was treated with the prescription pain medication, Darvocet. (Tr. 28-29) Dr. Pereles had told Claimant on his last appointment in early 2006 that he could not do anything more for Claimant without the diagnostic procedures because he did not know what the problem was or what to treat. (Tr. 29-30) Claimant last saw Dr. Levitt for an evaluation at the request of the Employer and Insurer on August 9, 2005. He testified that on that occasion Dr. Levitt's and Dr. Pereles' questions were similar. (Tr. 30-31, 33) Claimant had no new injuries since the 2004 surgery. (Tr. 31)

Claimant has diabetes, high blood pressure, and has had carpal tunnel surgery on his right wrist. (Tr. 33, 35) His employment after he left WMATA has not been directly computer related, but has involved proposing communications solutions, arranging for installation, and troubleshooting for a variety of companies over many years. (Tr. 33-34)

Dr. Collins

Dr. Robert Collins' medical records pertaining to his treatment of Claimant's injury extend from March 1974 to March 8, 2002. (E-7) The diagnosis stemming from Dr. Collins' initial exam was "Cervical strain and strain around the shoulders." Claimant was noted as complaining of pain around the left shoulder and around the neck in Dr. Collins' August 9, 1974, report, which recorded that Claimant was sent to therapy for massage and traction of the neck and exercise for the shoulder. These continuing complaints of neck pain were noted in subsequent reports into April 1975. In his April 10, 1975 report, Dr. Collins noted Claimant's complaints of pain around the scapula and around the neck, and the fact that the pain "seemed to move a little bit around the neck." Dr. Collins noted in his earlier February 27, 1975, report that Claimant was still complaining of pain around the shoulder and around the neck, and that he had had some muscle spasm in the neck, and consistently noted neck pain on February 14, January 14, 1975, and reports as early as August 9, 1974. Dr. Collins noted that Claimant had been seen by Dr. Neviaser who had advised surgery for the shoulder. Dr. Collins operated on Claimant on May 6, 1975, for acromioplasty and biceps tendon transfer of the right shoulder. Claimant had biceps tendonitis and the surgery effected the transfer of the biceps tendon with acromioplasty and resection of the acromioclavicular ligament with release of the acromioclavicular ligament.

Dr. Pereles (C-1)

In his deposition taken April 24, 2006, Dr. Pereles, qualified as an expert in orthopaedic surgery, testified that he specializes in orthopaedic surgery, in private practice, and is board-certified, recertified in 2003. (DTr. 3-4, 6) He is a specialist in sports medicine and arthroscopy, with seventy-five percent of his practice being shoulder and knee arthroscopy. (DTr. 5-6) His testimony was generally based on and corroborated by his detailed treatment records in evidence which extend from September 3, 2003, to May 15, 2006, and record assessments and prescribed treatments at relatively frequent intervals during the period, as well as a March 8, 2002, report by Dr. Collins of an office visit, and Dr. Levitt's report of January 6, 2004. (DTr. 38-41; C-3; E-8)

Dr. Pereles first examined Claimant on September 3, 2003, upon complaints of right shoulder pain. He took a medical history which disclosed prior treatment by Dr. Collins, including surgery. (DTr. 7) Physical examination disclosed a decreased range of motion and

tender shoulder with an impingement sign reflecting "irritation of the rotator cuff as a result of the acromium, which is a bone on top of the shoulder, rubbing against the underlying rotator cuff tendons." (DTr. 8) Dr. Pereles described the resulting symptoms as "pain and tenderness with internal and external rotation," which he explained as meaning rotating the shoulder while holding the arm out by the side. A neurologic test proved normal. There was an old surgical scar. X-rays revealed an acromium which was curved with calcific bone spurs off the front of that bone. (DTr. 9) Dr. Pereles explained that the entry, "terrible grade three" in his September 3, 2003, report meant that Claimant's acromium was very curved with a sharp front and some extra calcification which appeared to irritate the front of the rotator cuff, and he diagnosed a "terrible impingement, tendinitis from the calcification," tendinitis being inflammation of the tendon. He recommended treatment of a cortisone shot and an MRI. (DTr. 10) The MRI was performed on October 30, 2003, after which Dr. Pereles saw Claimant and noted an interpretation by Dr. Myles Koby of the MRI "as a full thickness rotator cuff tear with some postoperative changes, and a decreased space between the humerus, which is the ball part of the bone socket, and the acromium, which is the roof of the shoulder, with impingement at the muscle and tendon junction."

Dr. Pereles performed a right shoulder arthroscopy on Claimant on March 25, 2004, based on a preoperative diagnosis of "Possible rotator cuff tear with rotator cuff impingement syndrome," but the post operative diagnosis was "Rotator cuff impingement syndrome with no rotator cuff tear." (DTr. 11-12) The procedure was performed to remove the calcification and flatten out the acromium, to eliminate any irritation from the bone above the rotator cuff., and involved cleaning out the shoulder space, and the inflammation and the bursa on top of the rotator cuff, using mechanical means. The rotator cuff muscles were well attached to the bone. A closed manipulation of the shoulder was performed because Claimant had some adhesive capsulitis or frozen shoulder, causing loss of motion, and scar tissue was broken up in the process manually prior to the arthroscopy. He left the prior surgery intact. (DTr. 12-13)

Post operatively, Claimant underwent physical therapy to maintain his range of motion to avoid developing a recurrent adhesive capsulitis. (DTr. 13) But the symptoms persisted in the right shoulder. (DTr. 13-14) Dr. Pereles recorded on July 21, 2004, that Claimant had persistent pain in the right shoulder; that Claimant had had cortisone shot after the surgery which had helped some for about a week; that Claimant was missing some shoulder motion, but was working in physical therapy. Dr. Pereles suggested that the physical therapy be modified, and suggested a TENS unit to help with pain control. (DTr.14)

In August 2004, Dr. Pereles suggested a post-operative MRI since Claimant's shoulder pain had not improved much, and "had suggested MRI's of the cervical spine and an EMG to make sure we weren't missing a radiculopathic injury." (DTr. 15) Also in August, Dr. Pereles had administered a cortisone shot into the acromio-clavicular (AC) joint between the collar bone and acromium because it seemed to be a source of Claimant's pain, and considered resection for pain relief since Claimant complained of both pain in the shoulder and up into the neck. (DTr. 15-16) On April 25, 2005, Dr. Pereles injected cortisone into the subacromial space a second time and into the acromio-clavicular joint in response to Claimant's complaint of shoulder pain and signs of acromio-clavicular arthropathy, an inflammatory condition of the AC joint, possibly

secondary to some radiculopathy caused by a cervical disc impinging on the nerve root, causing pain which "can often be confused with right shoulder problems." (DTr. 17)

In his April 25, 2004, progress note, Dr. Pereles indicated that Claimant did not have significant signs of radiculopathy, but gets some radiculopathy down the right arm and some occasional tingling in the hand. (DTr. 17-18) Subsequently in his workup, Dr. Pereles recommended on May 10, 2005, that, because of the complicated nature of Claimant's condition and his failure to respond to conservative or operative methods of treatment, a cervical MRI and electro-myographic study (EMG) to Claimant's upper right extremity would rule out any kind of cervical disc problem or any nerve compressive problem. (DTr. 18) When Dr. Pereles saw Claimant on November 9, 2005, the symptoms were still present, and he was trying to determine whether Claimant had a cervical problem or a persistent continued shoulder problem. (DTr. 18-19)

When Dr. Pereles saw Claimant on February 21, 2006, he determined on physical examination that Claimant had decreased strength, pain in the biceps, that there was some radiculopathy reflected in pain down in the right shoulder from the neck into the right hand, and so he suggested EMG studies and an MRI of the cervical spine to determine whether the shoulder pain might be related to the cervical spine. (DTr. 19-20) Dr. Pereles opined that the MRI and EMG should be included as part of the workup related to the 1973 injury in order to help determine whether Claimant's problem is "a thirty-year-old missed cervical disc, or whether this is just persistent shoulder inflammation." (DTr. 21) Dr. Pereles testified that "there is one diagnosis which is often underlying or even more prevalent than the shoulder problem, and that is cervical radiculopathy or a herniated cervical disc. Which (sic) may be accompanying the shoulder problem, or may be causing the pain that he experiences in his shoulder and that's why we want the MRI of the cervical spine and the EMG studies to be done of the right upper extremity." (DTr. 21-22) Dr. Pereles testified that he could not offer any opinion as an orthopaedic surgeon regarding causal relationship regarding the neck or the cervical radiculopathy without the tests. (DTr. 22)

In a March 28, 2006, assessment provided to Claimant's lawyer, Dr. Pereles stated, "The diagnosis is recurrent right shoulder rotator cuff tendonitis, possible rotator cuff tear versus possible cervical radiculopathy secondary to cervical disc herniation…Objective signs of this injury are lacking since Workman's Compensation will not let us get an MRI or EMG studies. Clinical signs, however, are right cervical radiculopathy and right shoulder discomfort and right shoulder weakness as well as decreased right shoulder motion and a positive Speed's test….The symptoms that the client is experiencing are pain and neuropathy in the right upper extremity and the right shoulder."

In his last note of record, Dr. Pereles noted that they were waiting for approval of an MRI of the right shoulder and of the cervical spine to rule out radiculopathy that was in question. He observed, "I think that needs to be done in the future at some point in time, although today it seems more shoulder related than neck related. I think it is just a matter of clearing the cervical spine, making sure that is not the source of the pain and probably doing another arthroscopy of the right shoulder."

On cross-examination Dr. Pereles testified that he knew nothing about the 1973 accident except for what Claimant had told him, and had first encountered Claimant in 2003, thirty years after the initial injury occurred. He was not surprised to hear that Claimant's last medical treatment was sometime before 1984. (DTr. 24, 27-28) He testified that Claimant's is a very complicated case and that his concern about carpel tunnel versus cervical radiculopathy was still the differential diagnosis, and that he knew that Claimant had had prior right carpel tunnel surgery. (DTr. 27-28) To identify the specific symptoms that caused him to prescribe the MRI of the cervical spine and EMG of his right arm to see what, if any, nerves were being compressed, Dr. Pereles related the Claimant's history of complaints, the biceps tenodisis done in the 1970's or 1980's, the conservative workup, MRI which diagnosed the full thickness rotator cuff tear, the surgery which disclosed no tear, but calcific anterior acromium impingement which was remedied along with the bursitis. (DTr. 29)

Since Claimant had continued right shoulder pain, he had been given three cortisone injections into the acromio-clavicular joint and subacromial space, which provided no lasting relief for Claimant's continuing shoulder and related neck pain, with some right arm tingling. Dr. Pereles explained that because of that history, he was concerned "that perhaps the entire time, [Claimant] had cervical disc, which everyone was treating as right shoulder pathology." Recognizing that the past medical history was of an injury to the shoulder, but concerned with the possibility of cervical disc herniation and determining what, if any, nerves were being compressed, probably at C-5, 6, or 7, Dr. Pereles explained, "But the shoulder's right next to the neck, and these injuries often accompany each other, and sometimes, one gets missed or the work-up of the other because the patient's …explanation of the pain is more…apt to be towards one body part as opposed to another." (DTr.28-30, 34)

Dr. Pereles agreed that disc bulging or herniation could be the source of pain and could occur as age related and without trauma, and that arthritis in the cervical spine, which would be unrelated to the disc, could also cause compression on nerve roots. (DTr. 32-33) He also testified that the carpel tunnel compression symptoms that Claimant had were not a result of the shoulder injury. (DTr. 33) Dr. Pereles explained that he was concerned with the C-5, 6, and 7 nerve roots, because if those nerve roots are impinged, they would cause symptoms which can mimic carpel tunnel syndrome, shoulder impingement, and acromio-clavicular joint arthropathy. (DTr. 34-35) Over time, Claimant's symptoms have changed to include more pain in the biceps and radiating down his arm. Dr. Pereles testified that he had not touched the intact area of Dr. Collins' surgery, and that there was no arthritis in the area of the prior surgery. (DTr. 35-37) He agreed that there is a relationship between diabetes and carpel tunnel syndrome. (DTr. 38) He opined that before and after the 2004 surgery, Claimant was not at maximum medical improvement. Finally, Dr. Pereles testified that without the tests he sought, he had no objective data on the neck or the nerves, or the particular condition of any disc and could not opine regarding causation of Claimant's symptoms in relation to the 1973 injury. (DTr. 40-42)

Dr. Levitt (E-10)

In his deposition conducted August 15, 2006, Dr. Levitt, who is board-certified in orthopedic surgery and as an independent medical examiner, testified that he examined the

Claimant in January 2004 and determined that surgery recommended by Dr. Pereles was appropriate. He also examined Claimant in 2005 to determine whether additional medical diagnostic testing was required. He provided reports in both instances. (DTr. 6-7, 14; Exh. 1, 2, 3) He testified that most of his private practice was treating patients and less than ten percent doing independent medical examinations. (DTr. 7-8) He had reviewed medical records of Claimant, noting the shoulder injury thirty years before and original treatment by Dr. Collins, "a very noted orthopedist in the community," who saw Claimant from 1973 until 2002, and managed Claimant's treatment with medicines, then therapies and injections, which did not cure, and ultimately a surgical procedure described as an open decompression of the shoulder, which involved shaving off part of the shoulder blade complex called the acromion, and release of the coracoacromial ligament to the shoulder.

Dr. Levitt observed that even before the surgery there had been a lot of focus on Claimant's biceps tendon as a significant source of pain. (DTr. 9, 28) He identified Dr. Collins' diagnosis of Claimant as impingement syndrome and biceps tendonitis. (DTr. 33) Dr. Levitt was also impressed by the fact that prior to the surgery Claimant had been seen by Dr. Julius Neviaser, "who was sort of one of the senior deans of orthopedics in the metropolitan Washington area," and chairman at the time of the department of orthopedics at George Washington University, and father of the current chairman of that department. Dr. Levitt observed that Dr. Neviaser was a noted shoulder specialist and concurred that the biceps tendon seemed to be very inflamed. He explained the surgery which Dr. Collins had performed which was directed at decompressing the shoulder and performing a tenodesis of the biceps tendon, characterized as a very traditional treatment for biceps tendonitis, an inflammation causing pain in a shoulder joint. He noted that, although there were no complications with the surgery, Claimant did not get significant improvement, despite rehabilitation and additional injections, and ultimately had to change to less physically demanding work. (DTr. 9-11) Claimant had told Dr. Levitt that after seeing Dr. Collins occasionally into 2000 he changed orthopedic surgeons because Dr. Collins seemed to lose interest in Claimant's continuing shoulder problems. (DTr. 11)

Dr. Levitt reviewed Dr. Pereles' course of diagnosis and treatment, which included additional decompression of the subacromial space, but did not relieve Claimant's symptoms. Dr. Levitt had agreed after examination and evaluation in January 2004 that the surgery for impingement syndrome involving the rotator cuff was necessary and appropriate, especially because of the lack of cure, evidence of active inflammation, and after the MRI scan. (DTr. 11-13)

Dr. Levitt examined Claimant in August 2005 after Dr. Pereles' surgery which, Dr. Levitt said, did not disclose "anything new," verified that Claimant had inflammation and nothing structurally wrong with his shoulder, but produced no significant improvement. Claimant advised Dr. Levitt that Dr. Pereles "wanted to pursue additional diagnoses to determine whether there might be another source of his shoulder distress." The possibilities mentioned included Claimant's neck and carpal tunnel syndrome. (DTr. 13)

Dr. Levitt testified that in connection with his second evaluation, he had noted in his report that Claimant had gained twenty pounds between January 2004 and August 2005, but had

not pointed out that Claimant had gained 100 pounds of weight in the thirty years following the 1973 injury. (DTr. 15) His examination had disclosed some restrictions of right shoulder motion, a positive impingement test reflecting irritation under the shoulder blade with inflammation, but no weakness to the shoulder, and no gross neurologic deficits to Claimant's right upper extremity. (DTr. 15-16) Dr. Levitt testified that he routinely does a very comprehensive neuromuscular and neurologic examination, and when evaluating a shoulder, is sensitive to whether there are contributions above and below the shoulder that might be causing shoulder pain. Thus he thoroughly examines the neck, looking for disk disease or evidence of a root irritation from the nerves in the neck, and peripheral nerve problems like carpal tunnel syndrome, all as part of a standard examination. (DTr. 16)

In his January 2004 evaluation, he had found no evidence of any contributions from Claimant's neck or distal to the neck obstruction of the nerves in Claimant's hands or forearms. "In 2004 his complaints were isolated to the shoulder and I thought his exam was consistent with the primary shoulder disease." In the August 2005 examination, he also saw no evidence of cervical disk disease, or peripheral nerve disease like carpal tunnel syndrome, and concluded that Claimant's pathology was isolated to shoulder disease. (DTr. 16-17) His opinion based on the examination and review of the old medical records was that since the 1973 injury Claimant had been adequately treated, thoroughly managed by Dr. Collins, and never any complaints referable to the cervical spine or consistent with carpal tunnel disease, or documented findings of physicians objectively consistent with cervical or peripheral neuropathic processes. The problems were with his right shoulder.

Dr. Levitt observed that Dr. Pereles initially made an accurate assessment of shoulder pain which did not identify cervical disease or disease consistent with carpal tunnel, and correctly decided to rescope Claimant's shoulder. He observed that Dr. Pereles effectively confirmed that Dr. Collins had done a good job and that there was little left to do to Claimant's shoulder. Dr. Levitt opined that since there was no objective evidence of cervical disk disease or a peripheral neuropathic process contributing the Claimant's complaints clinically, there was no basis for ordering additional nerve studies or cervical radiographs or MRI scans, particularly as related to the 1973 injury. (DTr. 18) He categorically rejected the notion that the 1973 injury was manifesting itself thirty years later as a cervical problem or a peripheral nerve problem. DTr. 18-19) He suggested a probability of at least fifty percent that such tests would disclose a disk protrusion or degenerative disk disease in a fifty-two year old man that would be attributable to aging, obesity, diabetes, arthritic changes. (DTr. 19-20)

Dr. Levitt opined categorically that, differential diagnosis of other possible disease notwithstanding, Claimant's primary shoulder problem, with understandable complaints of shoulder pain even after thirty years and two surgical procedures, required no additional testing in the absence of objective clinical correlation. He opined that Claimant's residuals were not such that he thought something was being missed and something else was contributing to the residual. (DTr. 21-22, 29) And he opined categorically that there would be no causal linkage between any abnormality identified by such testing and the 1973 injury or the need for such testing and the 1973 injury. (DTr. 34-35) He declared that Dr. Collins had found no cervical pathology. (DTr. 35)

Dr. Levitt explained that the Tinel's test of nerve irritability and Phalen's test for carpal tunnel disease performed during his August 2005 examination were negative in 2004 and 2005, recognizing a substantial possibility of a positive or false positive EMG. (DTr. 30-32) Claimant had positive tests, including evidence of irritability primarily to the shoulder with limitation and pain as expected. (DTr. 32-33)

CONCLUSIONS OF LAW AND DISCUSSION

Under the circumstances presented by this record, this tribunal holds that the Employer is liable and should pay for the cost of the requested diagnostic testing because the Claimant has established that the tests would be a reasonable and necessary component of the diagnosis and treatment of the work-related injury which occurred in 1973. The Longshore and Harbor Workers' Compensation Act ("LHWCA") provides that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital services, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907. The definition of "medical care" includes laboratory, x-ray, and other technical services. § 702.401.

To prove entitlement to medical benefits, Claimant must show that the treatment is related to his work injury and is necessary and reasonable. *See generally, Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996); *Wheeler v. Interocean Stevedoring, Inc.*, 21 BRBS 33, (1988); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184 (1988); *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255 (1984).

Dr. Pereles' reports and deposition testimony establish Claimant's *prima facie* case. Dr. Pereles is a treating physician who is board-certified in orthopedic surgery, and who began treating the Claimant for his shoulder injury in 2003 and performed surgery on Claimant's shoulder in 2004. (CX 2; CX 5, pp. 3-4, 7, 11). After the surgery, Claimant continued to complain of right shoulder pain and related neck pain, and Dr. Pereles continued treatment with cortisone shots. (CX 2; CX 5, pp. 16, 29-30). Because the Claimant did not respond to the cortisone treatment and began to experience radiculopathy, Dr. Pereles determined it was necessary as a part of an appropriate workup to obtain an MRI of the cervical spine as well as an electromyography test to rule out the possibility that the cause of the Claimant's pain was a herniated disk which might have been overlooked since the date of the work-related injury. (CX 2; CX 5, p. 11).

Employer contends that the suggested diagnostic studies are not necessary to the treatment of Claimant's work-related shoulder injury, relying upon the opinion of Dr. Levitt. Dr. Levitt, who is board-certified in orthopedic surgery and independent medical examination, opined that the diagnostic studies recommended by Dr. Pereles are unnecessary and lack a history of clinical correlation. (EX 10, p. 6) First, Dr. Levitt points to the age of the work-related injury, thirty-plus years, and notes that "at no point in time had [the Claimant] had any

complaints referable to the cervical spine, and at no point in time did [the Claimant] have any complaints reported that were consistent with carpal tunnel disease . . . [s]o this was always about his right shoulder." (EX 10, p. 17).

Dr. Levitt's opinion is rendered less persuasive, first, by evidence in the record that the Claimant's medical history does in fact include complaints initially identified by Dr. Collins as cervically related, with periodic references to possible cervical problems thereafter, and carpal tunnel disease which caused the Claimant to undergo surgery on his right wrist. (CX 5, pp. 26-27). Claimant's medical history clearly documents pain related to his neck as well as the shoulder, though those complaints may not have been explicitly related to the cervical spine. Moreover, both Dr. Levitt and Dr. Pereles agree that in some cases, a patient may not accurately describe the location of the pain. (CX 5, p. 30; EX 10, p. 22). In fact, Dr. Levitt admitted that he trains his residents to evaluate the joint above and the joint below the area from which a patient indicates experience pain. (EX 10, p. 22). Therefore, Dr. Levitt's opinion that a lack of complaints related to the cervical spine and the lack of a medical history of carpal tunnel disease tend to show that the suggested diagnostic studies are not necessary to the treatment of the Claimant's work-related shoulder injury, is not persuasive.

Dr. Levitt opined that, because of Claimant's age, obesity, and history of diabetes, he would expect the Claimant to have undergone some degenerative changes to his cervical spine and would expect nerve studies to show some abnormality of nerve obstruction, such as carpal tunnel syndrome. (EX 10, p. 20). However, because Dr. Levitt framed the probabilities of such abnormalities in the realm of fifty percent, there is a substantial probability that such changes could be otherwise attributed to, and might indeed be related to, the work injury. Dr. Levitt categorically opined that these changes or abnormalities could not be the result of the work-related injury. (EX 10, p. 34). However, Dr. Levitt's assessment is premature, in that it relates to the possible or expected results of the diagnostic testing rather than the necessity of the diagnostic testing as part of a comprehensive workup after a long period of shoulder treatment which has not resolved the continuing symptoms. As Dr. Pereles pointed out in his February 21, 2006, progress note, without the MRI to rule out a possible missed cervical disk herniation, the Claimant's workup is incomplete. (CX 2).

Dr. Pereles has opined persuasively that the possibility that a cervical disk herniation is the cause of the Claimant's ongoing pain cannot be ruled out until the MRI and the EMG studies are obtained and the workup is completed. Only then would the cause of any such cervical disc herniation be ripe for determination. The need to rule out such a cause for Claimant's shoulder pain after such a protracted, varied, and unsuccessful course of treatment is patently reasonable, and the possibility that the cause of the pain might be related to the 1973 injury is sufficiently established on this record to justify the requested diagnostic studies. If such a cause were not ruled out by the requested tests, continuing treatment of the shoulder to relieve the pain might be unnecessary or inappropriate, since another cause, unrelated to the original injury, might be identified.

CONCLUSION

Claimant has established a *prima facie* case that the suggested diagnostic testing is necessary to the treatment of his work-related injury. Employer's evidence intended to rebut Claimant's case is not persuasive. Therefore, Employer should pay for the costs associated with the administration of the recommended MRI and the EMG.

ORDER

Respondent WMATA and its Carrier, The Schaffer Companies of Pennsylvania, are directed immediately to authorize and to pay the reasonable costs of medical care and treatment of Claimant specifically in the form of the requested diagnostic MRI and EMG medical testing as required and recommended by Dr. Pereles.

A

Edward Terhune Miller
Administrative Law Judge